		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044198

Facility Name: NORTHWOODS CARE CENTRE

Address: 2250 S. PEARL STREET (Number) BELVIDERE (City) 61108 (Zip Code)

County: BOONE

Telephone Number: (814) 544-0358 **Fax #** (815) 544-5006

IDPA ID Number: 36-3954529

Date of Initial License for Current Owners: 06/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHAEL BELLOWS

(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,836	4,691	2,852	21,379	8
9	SNF/PED					9
10	ICF	13,222	4,475	997	18,694	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,058	9,166	3,849	40,073	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.24%

D. How many bed-hold days during this year were paid by Public Aid?
125 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 1836

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,724	9,715	6,326	186,765		186,765	(4,648)	182,117			1
2	Food Purchase		137,602		137,602		137,602	(2,264)	135,338			2
3	Housekeeping	181,678	26,267	0	207,945		207,945	(2,209)	205,736			3
4	Laundry	44,840	23,271	772	68,883		68,883	412	69,295			4
5	Heat and Other Utilities			58,237	58,237		58,237	0	58,237			5
6	Maintenance	47,564	19,600	18,464	85,628		85,628	410	86,038			6
7	Other (specify):*			1,723	1,723		1,723	0	1,723			7
8	TOTAL General Services	444,806	216,455	85,522	746,783		746,783	(8,299)	738,484			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000	0	2,000			9
10	Nursing and Medical Records	1,384,118	68,023	26,620	1,478,761		1,478,761	23,697	1,502,458			10
10a	Therapy	0		3,885	3,885		3,885	0	3,885			10a
11	Activities	137,031	9,723	405	147,159		147,159	(784)	146,375			11
12	Social Services	44,536		324	44,860		44,860	0	44,860			12
13	Nurse Aide Training			1,742	1,742		1,742	0	1,742			13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,565,685	77,746	34,976	1,678,407		1,678,407	22,913	1,701,320			16
	C. General Administration											
17	Administrative	100,996		375,568	476,564		476,564	(367,457)	109,107			17
18	Directors Fees			0				0				18
19	Professional Services			169,162	169,162		169,162	43,213	212,375			19
20	Dues, Fees, Subscriptions & Promotions			49,012	49,012		49,012	(27,505)	21,507			20
21	Clerical & General Office Expenses	93,491	21,533	27,163	142,187		142,187	85,546	227,733			21
22	Employee Benefits & Payroll Taxes			328,407	328,407		328,407	0	328,407			22
23	Inservice Training & Education			6,475	6,475		6,475	0	6,475			23
24	Travel and Seminar			0				7,491	7,491			24
25	Other Admin. Staff Transportation			3,442	3,442		3,442	0	3,442			25
26	Insurance-Prop.Liab.Malpractice			6,473	6,473		6,473	60,781	67,254			26
27	Other (specify):*			16,653	16,653		16,653	(16,653)				27
28	TOTAL General Administration	194,487	21,533	982,355	1,198,375		1,198,375	(214,584)	983,791			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,204,978	315,734	1,102,853	3,623,565		3,623,565	(199,970)	3,423,595			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			75,013	75,013		75,013	39,795	114,808			30
31	Amortization of Pre-Op. & Org.			0				0				31
32	Interest			54,789	54,789		54,789	97,444	152,233			32
33	Real Estate Taxes			68,057	68,057		68,057	0	68,057			33
34	Rent-Facility & Grounds			485,139	485,139		485,139	(475,377)	9,762			34
35	Rent-Equipment & Vehicles			8,999	8,999		8,999	4,946	13,945			35
36	Other (specify):* STORAGE			1,728	1,728		1,728	0	1,728			36
37	TOTAL Ownership			693,725	693,725		693,725	(333,192)	360,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		50,779	67,113	117,892		117,892	0	117,892			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		50,779	132,993	183,772		183,772		183,772			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,204,978	366,513	1,929,571	4,501,062	0	4,501,062	(533,162)	3,967,900			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(43,343)	30		9
10	Interest and Other Investment Income	(45,530)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,264)	2		13
14	Non-Care Related Interest	(9,259)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(104)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,725)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,309)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(16,653)	27		24
25	Fund Raising, Advertising and Promotional	(24,308)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(581)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(989)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (148,065)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(393,549)	PG 6, 6A	34
35	Other- Attach Schedule VACATION ACC.	8,452	PG. 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (385,097)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (533,162)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS **Page 5A**

Facility Name NORTHWOODS CARE CENTRE

ID# 0044198

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	(4,648)
2	Other Care for Outpatients	0	0	Line 2	(2,264)
3	Governmental Sponsored Special Programs	0	0	Line 3	(2,209)
4	Non-Patient Meals	0	2	Line 4	412
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	34	Line 6	410
7	Sale of Supplies to Non-Patients	0	10	Line 7	0
8	Laundry for Non-Patients	0	4	Line 8	(8,299)
9	Non-Straightline Depreciation	(43,343)	30	Line 9	0
10	Interest and Other Investment Income	(45,530)	32	Line 10	17,680
11	Discounts, Allowances, Rebates & Refunds	0	2	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	(784)
13	Sales Tax	(2,264)	2	Line 12	0
14	Non-Care Related Interest	(9,259)	32	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	25	Line 15	0
17	Non-Care Related Fees	0	20	Line 16	16,896
18	Fines and Penalties	(104)	21	Line 17	(3,396)
19	Entertainment	0	20	Line 18	0
20	Contributions	(3,725)	20	Line 19	(1,309)
21	Owner or Key-Man Insurance	0	22	Line 20	(28,614)
22	Special Legal Fees & Legal Retainers	(1,309)	19	Line 21	(106)
23	Malpractice Insurance for Individuals	0	26	Line 22	0
24	Bad Debt	(16,653)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(24,308)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	13	Line 26	0
28	Yellow Page Advertising	(581)	20	Line 27	(16,653)
29	Non-Paid Workers	0	0	Line 28	(50,078)
30	Donated Goods	0	0	Line 29	(41,481)
31	Amortization Expense	0	0	Line 30	(43,343)
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(4,648)	1	Line 31	0
33	PAGE 5 - LINE 35 VACATION ACCRUAL	(2,209)	3	Line 32	(54,789)
34	PAGE 5 - LINE 35 VACATION ACCRUAL	412	4	Line 33	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	1,399	6	Line 34	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	17,680	10	Line 35	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	(784)	11	Line 36	0
38	PAGE 5 - LINE 35 VACATION ACCRUAL	(3,396)	17	Line 37	(98,132)
39	PAGE 5 - LINE 35 VACATION ACCRUAL	(2)	21	Line 38	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE	(989)	6	Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(139,613)
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

nary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(4,648)	0	0	0	0	0	0	0	0	0	0	(4,648)	1
2	Food Purchase	(2,264)	0	0	0	0	0	0	0	0	0	0	(2,264)	2
3	Housekeeping	(2,209)	0	0	0	0	0	0	0	0	0	0	(2,209)	3
4	Laundry	412	0	0	0	0	0	0	0	0	0	0	412	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	410	0	0	0	0	0	0	0	0	0	0	410	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,299)	0	0	0	0	0	0	0	0	0	0	(8,299)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	17,680	6,017	0	0	0	0	0	0	0	0	0	23,697	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(784)	0	0	0	0	0	0	0	0	0	0	(784)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	16,896	6,017	0	0	0	0	0	0	0	0	0	22,913	16
	C. General Administration													
17	Administrative	(3,396)	(364,061)	0	0	0	0	0	0	0	0	0	(367,457)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,309)	3,002	41,520	0	0	0	0	0	0	0	0	43,213	19
20	Fees, Subscriptions & Promotions	(28,614)	1,109	0	0	0	0	0	0	0	0	0	(27,505)	20
21	Clerical & General Office Expenses	(106)	83,691	1,961	0	0	0	0	0	0	0	0	85,546	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,491	0	0	0	0	0	0	0	0	0	7,491	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,570	57,211	0	0	0	0	0	0	0	0	60,781	26
27	Other (specify):*	(16,653)	0	0	0	0	0	0	0	0	0	0	(16,653)	27
28	**TOTAL General Administration**	(50,078)	(265,198)	100,692	0	0	0	0	0	0	0	0	(214,584)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,481)	(259,181)	100,692	0	0	0	0	0	0	0	0	(199,970)	29

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(43,343)	6,338	76,800	0	0	0	0	0	0	0	0	39,795	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(54,789)	0	152,233	0	0	0	0	0	0	0	0	97,444	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,762	(485,139)	0	0	0	0	0	0	0	0	(475,377)	34
35	Rent-Equipment & Vehicles	0	4,946	0	0	0	0	0	0	0	0	0	4,946	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(98,132)	21,046	(256,106)	0	0	0	0	0	0	0	0	(333,192)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(139,613)	(238,135)	(155,414)	0	0	0	0	0	0	0	0	(533,162)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number NORTHWOODS CARE CENTR # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				NORTHWOODS HEALTHCARE CENTRE		REAL ESTATE
					ROSEMONT	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	10	NURSING	$	FHC ENTERPRISES INC		$ 6,017	$ 6,017	1	6017
2	V	17	ADMINISTRATIV	375,568	MR. BELLOWS WONS 57% OF THIS FACILI		11,507	(364,061)	2	-364061
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISE		3,002	3,002	3	3002
4	V	20	DUES & SUBSCRIPTION		" "		1,109	1,109	4	1109
5	V	21	CLERICAL		" "		83,691	83,691	5	83691
6	V	24	TRAVEL		" "		7,491	7,491	6	7491
7	V	26	INSURANCE		" "		3,570	3,570	7	3570
8	V	30	DEPRECIATION		" "		6,338	6,338	8	6338
9	V	34	RENT		" "		9,762	9,762	9	9762
10	V	35	RENT-EQUIPMENT & VEH		" "		4,946	4,946	10	4946
11	V								11	
12	V								12	
13	V								13	
14	Total			$ 375,568			$ 137,433	$ * (238,135)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	RENT	$ 485,139	NORTHWOODS HEALTHCARE CENTRE	0.00%	$	$ (485,139)	15	-485139
16	V	19	ACCOUNTING				8,700	8,700	16	8700
17	V	19	LEGAL		" "		320	320	17	320
18	V	19	OTHER PROFESSIONAL		" "		32,500	32,500	18	32500
19	V	21	BANK CHARGES		" "		1,961	1,961	19	1961
20	V	26	GENERAL INSURANCE		" "		47,139	47,139	20	47139
21	V	26	MORTGAGE INSURANCE		" "		10,072	10,072	21	10072
22	V	30	DEPRECIATION		" "		76,800	76,800	22	76800
23	V	32	AMORTIZATION		" "		1,756	1,756	23	1756
24	V	32	INTEREST - MORTGAGE		" "		150,477	150,477	24	150477
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 485,139			$ 329,725	$ * (155,414)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT	ADMINISTRATIV	57%	SEE ATTACHED	1.87	5.45	SALARY	11,506	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,506		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 72,138	40,073	$ 6,017	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,966	137,966	40,073	11,507	2
3	19	PROFESSIONA FEES	PATIENT DAYS	480,456	10	35,987	0	40,073	3,002	3
4	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	480,456	10	13,291	0	40,073	1,109	4
5	21	CLERICAL	HOURS WORKED	1	1	21,788	21,788	1	21,788	5
6	24	TRAVEL	PATIENT DAYS	480,456	10	89,811	0	40,073	7,491	6
7	26	INSURANCE	PATIENT DAYS	480,456	10	42,804	0	40,073	3,570	7
8	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987	0	40,073	6,338	8
9	34	RENT	PATIENT DAYS	480,456	10	117,045	0	40,073	9,762	9
10	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305	0	40,073	4,946	10
11	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	51,247	40,073	61,903	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,408,304	$ 283,139		$ 137,433	25

[Print Preview]

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	GMAC		X	MORTGAGE		10/97	$ 2,052,500	$ 2,010,096		7.45	$ 150,477	1
2	GMAC		X	LOAN COST			61,456				1,756	2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	LINE OF CREDIT	VARIES	12/00	975,000	975,000	DEMAND	PRIME+	33,768	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	88,297	32,810	DEMAND	PRIME+	5,255	7
8	CRESTWOOD HEIGHTS	X		WORKING CAPITAL	VARIES	12/98	75,000	87,531	DEMAND	VARIES	6,507	8
9	TOTAL Facility Related						$ 3,252,253	$ 3,105,437			$ 197,763	9
	B. Non-Facility Related*											
10	NORTHWOODS HEALTHCA	X		WORKING CAPITAL	DEMAND	VARIES	238,870	102,273	DEMAND		9,259	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 238,870	$ 102,273			$ 9,259	14
15	TOTALS (line 9+line14)						$ 3,491,123	$ 3,207,710			$ 207,022	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	67,968	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	67,637	2
3. Under or (over) accrual (line 2 minus line 1).	$	(331)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	68,388	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	68,057	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	29,306	8
	1996	78,776	9
	1997	66,995	10
	1998	67,231	11
	1999	67,637	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2/BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1981	$ 50,050	1
2	754 BASIS ADJ		1992	4,835	2
3	TOTALS			$ 54,885	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1981		$ 995,068	$ 0	30	$ 33,169	$ 33,169	$ 663,380	4
5	754 BASIS ADJ		1992		111,968	3,555	31.5	3,555		30,215	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	RELATED PARTY-NORTHWOODS HEALTHCARE CENTRE										9
10	VARIOUS IMPROVEMENTS			1981	4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS			1982	73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS			1983	6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS			1984	11,372	290	20	569	279	9,390	13
14	PAVING			1986	13,000	653	15	867	214	12,571	14
15	SHOWER			1986	4,151	205	25	166	(39)	2,407	15
16	ROOF			1988	38,383	1,219	31.5	1,219		15,288	16
17	DECORATIONG			1989	1,921	61	31.5	61		689	17
18	VARIOUS IMPROVEMENTS			1990	10,047	319	31.5	319		3,509	18
19	VARIOUS IMPROVEMENTS			1991	2,683	85	31.5	85		933	19
20	VARIOUS IMPROVEMENTS			1992	38,565	1,224	31.5	1,224		10,166	20
21	CARPET			1993	6,854	217	31.5	217		1,670	21
22	DRIVEWAY			1993	1,655	42	39	42		298	22
23	SPRINKMAN SONS			1993	1,525	39	39	39		244	23
24	VARIOUS IMPROVEMENTS			1994	3,137	209	15	209		1,358	24
25	VARIOUS IMPROVEMENTS			1994	170,951	6,216	27.5	6,216		32,959	25
26	DOORS			1995	5,029	129	39	124	(5)	760	26
27	LANDSCAPING			1996	51,185	1,861	27.5	1,861		8,042	27
28	ROOF REPAIR			1996	20,000	727	27.5	727		3,015	28
29	DRIVEWAY REPAIR			1996	4,775	174	27.5	174		690	29
30	CONCRETE RETAINING WALL FOR RAMP			1997	1,500	55	27.5	55		183	30
31	WALL COVERING/HANDRAIL/FLOOR TILES			1997	46,256	1,682	27.5	1,682		5,491	31
32	DRYWALL/PAINTING/WALL PAPER INSTALLATION			1997	30,000	1,091	27.5	1,091		3,455	32
33	450000-GRAIN UNITS-WATER SOFTENER/COUNTER TOPS			1997	11,248	409	27.5	409		1,287	33
34											34
35					ADJ TO SL	33,618			(33,618)		35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 54,080		$ 54,080	$	$ 891,716	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	THREE WAY OVER BED RESIDENT LIGHTING			1998	12,600	458	27.5	458		1,037	9
10	GARBAGE DISPOSAL-KITCHEN REMODELING			1998	1,189	43	27.5	43		106	10
11	WINDOWS ND AUTO DOOR SYSTEM			1998	25,000	909	27.5	909		2,083	11
12	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS			1998	68,941	2,507	27.5	2,507		6,828	12
13	TILES			1998	3,164	115	27.5	115		302	13
14	WOOD FLOORING			1998	4,705	171	27.5	171		420	14
15	COUNTER TOPS			1998	17,763	646	27.5	646		1,583	15
16	ELECTRICAL WIRING			1998	3,675	134	27.5	134		340	16
17	REMODELING-PAINTING/DRYWALL/WALLPAPER			1998	125,000	4,545	27.5	4,545		11,122	17
18	WALLCOVERING/TILES/HAND RAILS			1999	29,035	1,056	27.5	1,056		2,068	18
19	REMODELING-HALLS/REHAB/OFFICES WASHROOMS			1999	100,000	3,636	27.5	3,636		6,818	19
20	TILES			1999	3,924	143	27.5	143		161	20
21	STAINLESS STEEL WALLS IN THE KITCHEN			1999	2,628	96	27.5	96		108	21
22	REMODELING - ARCHITECTURE			2000	4,000	139	27.5	139		139	22
23	BLACKTOP STRIPPING & SEALING			2000	4,050	135	15	135		135	23
24	AIRTHERM HEATERS			2000	34,363	365	27.5	365		365	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 15,098		$ 15,098	$	$ 33,615	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
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14											14
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 411,003	$ 70,888	$ 30,542	$ (40,346)	3-15 YRS	$ 95,002	37
38	Current Year Purchases	28,439	4,125	1,128	(2,997)	3-15 YRS	1,128	38
39	Fully Depreciated Assets							39
40	RELATED PARTIES	412,979	13,960	13,960			392,043	40
41	TOTALS	$ 852,421	$ 88,973	$ 45,630	$ (43,343)		$ 488,173	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 158,151	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 114,808	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (43,343)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,413,504	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 8,999 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [X]
   - HOURS PER AIDE 90

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,447	$	$ 1,447
2	Books and Supplies		141		141
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		154		154
9	TOTALS	$	$ 1,742	$	$ 1,742
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,742			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 24,613	$		$ 24,613	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,754			5,754	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			36,746			36,746	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				41,025		41,025	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2					9,754		9,754	13
14	TOTAL			$		$ 67,113	$ 50,779		$ 117,892	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,029	$ 104,508	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,266)	755,188	755,188	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,834	86,593	6
7	Other Prepaid Expenses	6,187	6,187	7
8	Accounts Receivable (owners or related parties)	1,352,355	1,905,759	8
9	Other(specify): ESCROW DEPOSITS		36,631	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,203,593	$ 2,894,866	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		997,991	15
16	Equipment, at Historical Cost	439,441	849,508	16
17	Accumulated Depreciation (book methods)	(249,703)	(1,791,783)	17
18	Deferred Charges		55,749	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		258,380	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 189,738	$ 1,414,963	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,393,331	$ 4,309,829	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 187,910	$ 223,760	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	139,705	139,705	28
29	Short-Term Notes Payable	1,383,302	1,095,341	29
30	Accrued Salaries Payable	43,141	43,141	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,396	5,396	31
32	Accrued Real Estate Taxes(Sch.IX-B)		68,388	32
33	Accrued Interest Payable	5,625	5,625	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	4,940	4,940	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,770,019	$ 1,586,296	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	86,051	86,051	39
40	Mortgage Payable		2,010,096	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 86,051	$ 2,096,147	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,856,070	$ 3,682,443	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 537,261	$ 627,386	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,393,331	$ 4,309,829	48

***(See instructions.)**

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 199,177	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 199,181	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	338,080	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 338,080	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 537,261	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,779,074	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,779,074	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60,068	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60,068	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,839,142	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 746,783	31
32	Health Care	1,678,407	32
33	General Administration	1,198,375	33
	B. Capital Expense		
34	Ownership	693,725	34
	C. Ancillary Expense		
35	Special Cost Centers	117,892	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,501,062	40
41	**Income before Income Taxes (line 30 minus line 40)****	338,080	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 338,080	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,998	2,179	$ 66,111	$ 30.34	1
2	Assistant Director of Nursing	1,972	2,249	43,100	19.16	2
3	Registered Nurses	19,244	23,307	470,600	20.19	3
4	Licensed Practical Nurses	10,923	12,131	182,122	15.01	4
5	Nurse Aides & Orderlies	48,872	52,252	564,998	10.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,006	2,243	27,981	12.47	9
10	Activity Assistants	14,784	15,838	109,050	6.89	10
11	Social Service Workers	3,250	3,652	44,536	12.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,388	8,888	96,344	10.84	14
15	Cook Helpers/Assistants	8,968	9,820	74,380	7.57	15
16	Dishwashers					16
17	Maintenance Workers	2,031	2,420	47,564	19.65	17
18	Housekeepers	19,492	20,576	181,678	8.83	18
19	Laundry	5,595	6,067	44,840	7.39	19
20	Administrator	1,985	2,134	100,996	47.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,172	6,970	93,491	13.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,039	4,499	57,187	12.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,719	175,225	$ 2,204,978 *	$ 12.58	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	179	$ 6,326	1-3	35
36	Medical Director	16	2,000	9-3	36
37	Medical Records Consultant	20	960	10-3	37
38	Nurse Consultant	323	12,820	10-3	38
39	Pharmacist Consultant	240	1,440	10-3	39
40	Physical Therapy Consultant	31	1,627	10a-3	40
41	Occupational Therapy Consultant	35	2,258	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	8	405	11-3	44
45	Social Service Consultant	6	324	12-3	45
46	Other(specify)				46
47	UTILIZATION REVIEW FEES	32	11,400	10-3	47
48					48
49	TOTAL (lines 35 - 48)	890	$ 39,560		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

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0

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN MEAD	ADMIN		$ 100,996
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,996

B. Administrative - Other

Description		Amount
		$
FIRST HEALTH CARE	MANAGEMENT FEES	375,568
TOTAL (agree to Schedule V, line 17, col. 3)		$ 375,568
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATACHED SCHEDULE		169,162
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 169,162

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,360
Unemployment Compensation Insurance	17,168
FICA Taxes	165,814
Employee Health Insurance	86,734
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	12,810
EMPLOYEE BENEFITS-OTHER	7,949
EMPLOYEE PHYSICAL EXAMS	2,572
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 328,407

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,923
Health Care Worker Background Check	1,404
(Indicate # of checks performed 59)	
ADV & PROMO/MARKETING	24,889
DUES & SUBSCRIPTIONS	6,042
LICENSES & PERMITS	7,829
TRUST FEES, CONTRIBUTIONS,etc.	3,725
MGMT CO ALLOCATION	1,109
LESS TRUST FEES, CONTRIB, etc.	(3,725)
Less: Public Relations Expense	( )
Non-allowable advertising	(24,308)
Yellow page advertising	(581)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,507

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MANAGEMENT COMPANY ALLOC.	7,491
	0
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,491

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	1997	$ 3,488	3	$ 581	$ 1,163	$ 1,163	$ 581	$	$	$	$	$
2	PAINT/DECORATINC	1998	1,534	3		256	511	511	256				
3	PAINT/DECORATINC	2000	2,497	3				416	832	832	417		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,519		$ 581	$ 1,419	$ 1,674	$ 1,508	$ 1,088	$ 832	$ 417	$	$

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Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $4374

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,201 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,880
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	6326	
	REPAIRS & MAINTENANCE		0	
			0	6326
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		772	
			0	772
5	HEAT & OTHER UTILITIES			
	GAS HEAT		8068	
	ELECTRICITY		33966	
	WATER		15423	
	CABLE TV - LOBBY		780	
			0	58237
6	MAINTENANCE			
	GROUNDS MAINTENANCE		910	
	PAINTING & DECORATING		2497	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9413	
	ELEVATOR MAINTENANCE & REPAIR		3115	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		280	
	FIRE SERVICE		2249	
			0	
			0	
			0	18464
7	OTHER			
	SCAVENGER		1723	
	SECURITY SERVICE		0	1723
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	2000	2000

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	960	
	PHARMACY CONSULTANT	XVIII B39	1440	
	UTILIZATION REVIEW FEES	XVIII B	11400	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	12820	
			0	
			0	26620
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	1627	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	2258	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	3885
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	405	
			0	405
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	324	
	SOCIAL WORKER	XVIII B45	0	
			0	324
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	1742	1742

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		0	0
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	375568	375568
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	14088	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	155074	
	ACCOUNT COLLECTION FEES		0	169162
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	24308	
	EMPLOYEE WANT ADS	XIX F	4923	
	CONTRIBUTIONS	VI 20 XIX F	975	
	DUES & SUBSCRIPTIONS	XIX F	6042	
	LICENSES & PERMITS	XIX F	8029	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	581	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2750	
	H/CARE WORKER BACKGROUND CHECK	XIX F	1404	49012
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		385	
	EQUIPMENT REPAIR & MAINTENANCE		700	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES	VI 18	104	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		170	
	TELEPHONE		25804	
	MESSENGER SERVICE		0	
			0	27163

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	165814	
	UNEMPLOYMENT COMPENSATION	XIX D	17168	
	WORKERS COMPENSATION INSURANCE	XIX D	35360	
	HOSPITALIZATION INSURANCE	XIX D	86734	
	EMPLOYEE BENEFITS - OTHER	XIX D	7949	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2572	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRIB	XIX D	12810	
	CHICAGO HEAD TAX	XIX D	0	328407
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		6475	6475
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		3442	3442
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		6473	6473
27	OTHER			
	BAD DEBTS	VI 24	16653	
			0	16653
	GRAND TOTAL COLUMN 3 OTHER			1102853

NORTHWOODS CARE CENTRE - DIAGNOSTICS - 12/31/2000
This report reflects a 366-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 32-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5 Line 29-1 consists of 1508 from Page 22 and -2497 from Page 3 Line 6-3.
Related organization cost on Page 5 Line 34 = Page 6 Line 14-8.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10.
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 48-2.
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 49-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 10-1.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 41-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198
EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 COLUMN 3 OTHER LINES 2 AND 22

TOTAL FOOD PURCHASE	0	PATIENT MEALS	120219
LESS SALES TAX	-2264	ADD EMPLOYEE MEALS	0
NET FOOD	2264	TOTAL MEALS/YEAR	120219
TOTAL PATIENT CENSUS	40073	NET FOOD	2264
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	120219
TOTAL PATIENT MEALS	120219	COST PER MEAL	0.02
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

NORTHWOODS CARE CENTRE - COMPARISONS - 12/31/2000

	ref.	12/31/2000			12/31/1999			DIFF	12/31/1998		
CAPACITY DAYS		43920			43800			-43800	43800		
CENSUS DAYS		40073			41001			-41001	41656		
OCCUPANCY %		0.91240893			0.93609589				0.95105023		
SALARIES											
TOTAL General Services	8-1	444806	0.11210111	11.0998927	378420	0.10470723	9.22953099	-378419.89	350832	0.08982759	8.42212406
Social Services	12-1	44536	0.01122407	1.11137175	43355	0.01199615	1.05741323	-43354.989	45838	0.01173644	1.1003937
TOTAL Health Care and Programs	16-1	1565685	0.39458782	39.0708208	1489308	0.4120853	36.3236994	-1489307.6	1482469	0.37957377	35.5883666
Clerical & General Office Expenses	21-1	93491	0.02356183	2.33301724	87100	0.02410021	2.12433843	-87099.976	84277	0.02157842	2.02316593
TOTAL General Administration	28-1	194487	0.0490151	4.8533177	182654	0.0505396	4.45486695	-182653.95	174972	0.04480011	4.2004033
TOTAL Operation Expense	29-1	2204978	0.55570402	55.0240311	2050382	0.56733213	50.0080974	-2050381.4	2008273	0.51420148	48.210894
ADJUSTED TOTALS											
Food	2-8	135338	0.03410822	3.37728645	135620	0.03752549	3.3077242	-135619.97	133328	0.03413752	3.20069138
Heat and Other Utilities	5-8	58237	0.01467703	1.45327278	73450	0.02032331	1.79141972	-73449.985	76610	0.01961535	1.83911081
Maintenance	6-8	86038	0.02168351	2.14703167	98348	0.02721248	2.3986732	-98347.978	92992	0.02380982	2.23237949
TOTAL General Services	8-8	738484	0.18611457	18.428468	698054	0.19314862	17.0252921	-698053.81	672117	0.17208993	16.1349385
Administrative	17-8	109107	0.02749742	2.72270606	105701	0.02924702	2.57801029	-105700.97	103043	0.0263833	2.47366526
Directors Fees	18-8				0			0	0		
Professional Services	19-8	212375	0.05352327	5.29970304	136337	0.03772388	3.32521158	-136336.95	158800	0.04065941	3.81217592
Fees, Subscriptions, Promotions	20-8	21507	0.00542025	0.53669553	11776	0.00325837	0.28721251	-11775.995	15556	0.00398298	0.3734396
License Fee-IDPA	Pg21	200	5.0404E-05	0.00499089	200	5.5339E-05	0.00487793	-199.99995	200	5.1208E-05	0.00480123
License Fee-Other	Pg21	7829	0.00197308	0.19536845	371	0.00010265	0.00904856	-370.99803	435	0.00011138	0.01044267
Clerical & General Office Expenses	21-8	227733	0.05739384	5.68295361	209097	0.05785627	5.09980244	-209096.94	222794	0.05704454	5.3484252
Employee Benefits & Payroll Taxes	22-8	328407	0.08276595	8.19521873	308210	0.08528042	7.51713373	-308209.92	405188	0.10374499	9.72700211
Payroll Taxes	Pg21	182982	0.04611558	4.56621665	171061	0.04733186	4.17211775	-171060.95	167235	0.04281912	4.01466775
W/C Insurance	Pg21	35360	0.00891151	0.88238964	27981	0.00774223	0.68244677	-27980.991	48994	0.0125445	1.1761571
Health Insurance	Pg21	86734	0.02185892	2.16439997	86766	0.02400779	2.11619229	-86765.978	168297	0.04309104	4.04016228
Inservice Training & Education	23-8	6475	0.00163185	0.16158012	7740	0.00214163	0.18877588	-7739.9984	8459	0.00216586	0.20306799
Travel and Seminar	24-8	7491	0.0018879	0.18693385	6472	0.00179078	0.15784981	-6471.9981	7312	0.00187218	0.17553294
Other Admin. Staff Transportation	25-8	3442	0.00086746	0.08589324	3764	0.00104148	0.09180264	-3763.9991	3397	0.00086977	0.08154888
Insurance-Prop.Liab.Malpractice	26-8	67254	0.01694952	1.67828713	41117	0.0113769	1.0028292	-41116.983	38306	0.00980793	0.91957941
Other (specify):*	27-8				0			0	0		
TOTAL General Administration	28-8	983791	0.24793745	24.5499713	830214	0.22971674	20.2486281	-830213.75	964855	0.24704304	23.1624496
TOTAL Operation Expense	29-8	3423595	0.8628229	85.433958	3114724	0.86183111	75.9670252	-3114723.1	3246619	0.8312696	77.9388083
Real Estate Taxes	33-3	68057	0.01715189	1.69832556	67471	0.01866894	1.64559401	-67470.983	55079	0.01410252	1.32223449
Real Estate Legal	Pg10	0			0			0	6863	0.00175721	0.16475418
GRAND TOTAL COST	45-8	3967900	1	99.0167944	3614077	1	88.1460696	-3614076	3905615	1	93.7587622
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1489083.6	0.37528254	37.1592742	1304397.71	0.36092139	31.8138023	-1304397.3	1337869.91	0.34255038	32.1170998

NORTHWOODS CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2000

INCOME PER F/S									4,576,702	
	NURSING	EMPL BENEI	PLANT	LAUNDRY	DIETARY	GENL/ADMI	OTHER INC/I	CAPITAL		SALARIES
PER COST REPORT	1,678,407	328407	353533	68883	324367	869968	65880	693725		2204978
ADJUSTMENTS:										
EQUIP RENTAL/AUTO LEASE	5930		3069			0		-8999		
CABLE TV	0		-780			780				
CONTRACT NURSING										0
INTEREST INCOME							(60,068)			
NET VENDING COMMISSIONS							0			
EMPLOYEE PHYSICAL EXAMS		-2572				2572				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						-375568		375568		
BAD DEBTS						-16653	16653			
NURSE AID REIMB-STATE										
PROFIT SHARING										
PRIOR EXPENSES							-84480			
RECLASSED SALARIES	0					0				
RECLASSED SALARIES										
DISCOUNTS							0			
ANCILLARY										
TOTAL COSTS	1684337	325835	355822	68883	324367	481099	-62015	1060294	4238622	2204978
PER FINANCIAL STATEMENTS	1684337	325835	355822	68883	324367	481099	-62015	1060294	338080	2204978
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									338080	